(iii) a non-comparable component which shall be equivalent to the 1988 statewide average non-comparable cost per day for hospital-based residential health care facilities, trended to the appropriate rate year.

(2) For general hospitals with more than 49 beds, the maximum number of days for which the operating component of the rate as defined in paragraph (1) of this subdivision shall be paid shall be equivalent to fifteen (15) percent of a hospital's total annual patient days for acute, exempt unit, and alternate level of care services, excluding swing bed days.

(3) The operating component of the rate as defined in paragraph (1) of this subdivision shall be paid for the first sixty (60) days per year during which a patient is receiving care as a participant in the swing bed program. Any patient stay in excess of sixty (60) days per year shall be reimbursed at the prevailing average rate paid for the care of Alternate Level of Care (ALC) patients pursuant to the provisions of section 86-1.56 of this Subpart. The sixty-day period shall begin the first day on which the patient receives care as a participant in the swing bed program.

(4) A capital cost per diem shall be paid on the basis of budgeted capital costs allocated to the swing bed program, pursuant to the provisions of section 86-1.59 of this Subpart, divided by patient days associated with the swing bed program, reconciled to actual total capital expense.

86-1.74 Supplementary Bad Debt and Charity Care Disproportionate Share Adjustment. (a) The rates of payment made to major public hospitals as defined in section 86-1.65[(c)] (b) of this Subpart for the periods July 1, 1989 through December 31, 1989, and January 1, 1990 through December 31, 1990, for a person eligible for payments made by State governmental agencies applicable to patients eligible for medical assistance pursuant to Title [XI] 11 of Article 5 of the Social Services Law shall include a supplementary bad debt and charity care adjustment determined in accordance with subdivision (b) of this section. Rates of payment to such major public hospitals for rate years commencing January 1, 1991 and thereafter for persons eligible for federal financial participation under Title XIX of the federal Social Security Act in medical assistance paid by State governmental agencies pursuant to Title 11 of Article 5 of the Social Services Law, shall include a supplementary bad debt and charity care adjustment determined in accordance with subdivision (b) of this section. Such adjustments shall be made provided the State governmental agency or the government of the county in which the hospital is located or the city of New York for a general hospital operated by the New York City Health and Hospitals Corporation files with the Commissioner in writing an election for such adjustment by September 1, 1989 for the period July 1, 1989 through December 31, 1989, by October 15, 1989 for the period January 1, 1990 through December 31, 1990, and by October 15 of the rate year preceding the rate year for rate years commencing January 1, 1991 and thereafter for such hospital for each period. Such election is subject to the approval of the State Director of the Budget and contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

(b) The supplementary bad debt and charity care adjustment shall be determined for the period July 1, 1989 through December 31, 1989 based on historical data collected for the period April 1, 1989 through December 31, 1989 and for the period January 1 through December 31 for each subsequent rate period based on the amount calculated by subtracting the amount projected to be distributed to such major public hospitals pursuant to section 86-1.65[(k)(1)] (d) of this Subpart for such period from an amount calculated as the product of the projected bad debt and charity care nominal

payment amount coverage ratio for such period for voluntary sector hospitals as defined in section 86-1.65[(c)(2)] (b) of this Subpart multiplied by the base

year bad debt and charity care imputed nominal payment amount for such major public hospital determined in accordance with section 86-1.65(b) of this Subpart for voluntary sector hospitals. The coverage ratio shall be computed as the ratio between the sum of the dollar value of the amount committed for payments in accordance with section 86-1.65(d)(1) and (2) of this Subpart for the rate period that would be allocated to voluntary sector hospitals and the base year nominal payment amount for such hospitals. For the rate periods commencing on or after January 1, 1994, provided the election pursuant to paragraph (a) of this section continued for such periods and a major public general hospital received an adjustment in accordance with this paragraph for 1993, the supplementary bad debt and charity care adjustment shall be the higher of such adjustment for the 1991 rate period or 1993 rate period. For rate periods commencing prior to January 1, 1991, this additional amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable cost and divided by Medicaid service units to arrive at a cost per unit of service. For rate periods commencing January 1, 1991 and thereafter, this additional amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable costs and divided by Medicaid service units of those patients eligible for Federal financial participation under title XIX of the Federal Social Security Act in medical assistance pursuant to title 11 of article 5 of the Social Services Law to arrive at a cost per unit of service.

(c) The supplementary bad debt and charity care adjustment provided in accordance with this section shall be adjusted to reflect actual distributions pursuant to section 86-1.65 (d) of this Subpart.

86-1.75 Estimate of real non-Medicare cumulative case mix increase. (a) For purposes of the computation pursuant to section 86-1.60(b) for historical rate years commencing January 1, [~~1988~~] 1994 an estimated real non-Medicare cumulative case mix increase and an estimated non-Medicare cumulative case mix increase to be attributable to changes in coding practices shall be determined based on those non-Medicare discharges for which the hospital has submitted Discharge Data Abstracts (DDAs) for 1992 and universal data sets (UDSs) for each rate year beginning January 1, 1994, submitted no later than April 30 of the following rate year to the Statewide Planning and Research Cooperative System (SPARCS). Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics and other catastrophes resulting in extraordinary hospital utilization shall be exempted from the provisions of this section.

(b) The case mix indices used in estimating the reported non-Medicare case mix increase, the estimated real non-Medicare case mix increase and the non-Medicare case mix increase estimated to be attributable to changes in coding practices pursuant to subdivisions (c), (d) and (e), respectively, of this section shall be as follows:

(1) A reported base year case mix index for each hospital shall be determined based on those [~~1987~~] 1992 discharges, hereafter referred to as base year discharges, for which the hospital has submitted DDAs pursuant to subdivision (a) of this section and such discharges that would not be exempt from the case payment reimbursement system.

(2) A statewide reported base year case mix index shall be determined by multiplying the base year case mix index for each hospital determined pursuant to paragraph (1) of this subdivision by the base year discharges

and dividing the statewide sum of the results by the sum of the base year discharges.

(3) A reported rate year case mix index for each hospital shall be determined based on those rate year discharges, hereafter referred to as rate year discharges, for which the hospital has submitted DDAs **pursuant to subdivision (a) of this section** and such discharges that would not be exempt from the case payment reimbursement system.

(4) A statewide reported rate year case mix index shall be determined by multiplying the rate year case mix index for each hospital determined pursuant to paragraph (3) of this subdivision by the rate year discharges and dividing the sum of the results by the statewide sum of the rate year discharges.

(5) Estimated real base and rate year case mix indices for each hospital shall be determined based on the following:

[~~(i) discharges which are coded with a nonspecific principal diagnosis or procedure shall have an average SIW value assigned based on the DRGs that would have resulted if a specific diagnosis or procedure was used. The average SIW value shall be determined using a statewide distribution of the non Medicare discharges assigned to those DRGs in the rate year.~~]

(i) [(~~ii~~)] discharges [~~not assigned a new SIW value pursuant to subparagraph (i) of this paragraph~~] which are classified into DRGs that are split on the presence of a complication and/or comorbidity which, because of their nature are more susceptible to changes in coding practices, shall

TN 94-06 [illegible] JAN 0 1 1994

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have SIW values assigned to those DRGs in the base year to reflect the same proportion of cases split on the presence of a complication and/or comorbidity in the rate year.

(ii) [~~(iii)~~] Discharges in the rate year that have been coded more accurately due to the incentives in the case payment system and/or with new codes necessitated by changes in the New York State grouper which did not previously exist in the base year shall be treated consistently in each year with respect to DRG assignment.

(6) Estimated real statewide base year and rate year case mix indices shall be determined based upon the hospital-specific estimated real base and rate year case mix indices determined pursuant to paragraph (5) of this subdivision except:

(i) if the estimated non-Medicare case mix increase to be attributable to changes in coding practices determined pursuant to subdivision (e) of this section for a hospital is equal to zero, the reported base year and rate year case mix indices for the hospital shall be used in the determination of the estimated real statewide base year and rate year case mix indices; or

(ii) if the estimated non-Medicare case mix increase to be attributable to changes in coding practices determined pursuant to subdivision (e) of this section for any hospital is greater than zero, the hospital's estimated real base year and rate year case mix indices as determined pursuant to paragraph (5) of this subdivision shall be modified to reflect the adjustments made pursuant to paragraph (2) of

subdivision (e) of this section and be used in the determination of the estimated real statewide base year and rate year case mix indices.

(c) The reported non-Medicare case mix increase for each hospital shall be determined by subtracting 1 from the result of dividing the reported rate year case mix index determined pursuant to paragraph (3) of subdivision (b) of this section by the reported base year case mix index determined pursuant to paragraph (1) of subdivision (b) of this section.

(d) The estimated real non-Medicare case mix increase for each hospital shall be determined by subtracting 1 from the result of dividing the estimated real rate year case mix index determined pursuant to paragraph (5) of subdivision (b) of this section by the estimated real base year case mix index determined pursuant to paragraph (5) of subdivision (b) of this section.

(e) The estimated non-Medicare case mix increase estimated to be attributable to changes in coding practices for each facility shall be:

(1) zero for those facilities where the result of subtracting the estimated real non-Medicare case mix increase determined pursuant to subdivision (d) of this section from the reported non-Medicare case mix increase determined pursuant to subdivision (c) of this section is less than .005.

(2) for all other hospitals, the greater of .005 or one-half of the difference between the estimated real non-Medicare case mix increase and the reported non-Medicare case mix increase with a maximum of .02 shall

be subtracted from the result of subtracting the estimated real non-Medicare case mix increase determined pursuant to subdivision (d) of this section from the reported non-Medicare case mix increase determined pursuant to subdivision (c) of this section.

(f) An adjusted real non-Medicare case mix increase shall be the reported non-Medicare case mix increase determined pursuant to subdivision (c) of this section less the estimated non-Medicare case mix increase estimated to be attributable to coding practices determined pursuant to subdivision (e) of this section.

(g) The case mix indices determined pursuant to this section shall be the result of dividing the sum of weighted discharges by the sum of actual discharges where weighted discharges shall be determined as follows:

(1) the weighted discharge for an inlier case shall be the corresponding SIW determined pursuant to section 86-1.62 of this Subpart.

(2) the weighted discharge for a short stay discharge shall be the result of multiplying the number of days for that case by the short stay weighting factor of 1.5 and the SIW determined pursuant to section 86-1.62 of this Subpart and dividing the result by the average length of stay for the DRG determined pursuant to section 86-1.62 of this Subpart.

(3) the weighted discharge for a transfer discharge shall be the result of multiplying the number of days for that case by the transfer weighting factor of 1.2 and the SIW determined pursuant to section 86-1.62 of this Subpart and dividing the result by the average length of stay for the DRG determined pursuant to section 86-1 62 of this Subpart.

86-1.76 Reserved